SELF-HELP GROUPS FOR WOMEN WITH PAIN— A RESEARCH REVIEW WITH A GENDER PERSPECTIVE

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ABSTRACT

It is the aim of this review to provide a survey of research on Self-Help Groups (SHGs) in health care with a special focus on SHGs for women with chronic muscular pain. The aim is not only to describe this field of research, but also to consider how this research relates to gender research as such. A variety of themes are examined: history, external factors that influence SHGs, internal aspects of SHGs, and gender research on SHGs. It was found that the gender perspective was relatively neglected. Our suggestion for further research notes that group members can produce new ways to manage their lives with the help of the interaction/exchange in the SHGs, regarding gender construction, knowledge, legitimacy and adaptation or transformation, and the position of activities in SHGs among societal norms and attitudes.

INTRODUCTION

This review is a part of a larger research project on Self-Help Groups (SHGs) for women with chronic muscular pain. Often these women are experiencing difficulties to get acknowledgment and validation of the legitimacy of their

illness (Malterud, 1994; Säljö & Sätterlund-Larsson, 1996), and in obtaining adequate care.

SHGs for mutual support have become an appreciated alternative in different fields of treatment and care m mamy countries (Adamsen, 2002; Borkman, 1990; Wituk, Shepherd, Slavich, Warrren, & Meissen, 2000). Researchers have presented an increasing interest for participation by professionals in the activities of SHGs (Adamsen & Rasmussen, 2001; Borkman, 1990; Karlsson, 2002). This participation seems greater in the Nordic countries than in other Western countries (Adamsen & Rasmussen, 2001; Karlsson, 2002). The problem areas where SHGs exist are many, potentially involving a wide range of professionals in SHG activities. Our initial position in this article represents a social worker's point of view, due to our background in social work research and practice.

The problems that SHGs deal with are often related to the individual's social situation (Karlsson, 2002), and participation in SHGs appears to be more advantageous to people with chronic rather than acute diseases (Hatch & Kickbusch, 1983). The decision to participate in an SHG is generally made at an individual level (Bakker & Karel, 1983), and the reasons for participation seem to be various, for example to meet others in a similar situation, to help oneself and others, and to join the group's social activities (Richardson, 1983). Another reason, seen from a societal level, is the will to change the situation for others in the same situation with the help of the SHG (Moeller, 1983; Richardson, 1983).

Some SHGs are groups of women. Glaser (1976) presented a special reason for women to join such groups, namely that they felt more comfortable to work exclusively with other women. It has also been said that women's groups are important for women's development of an identity and of individuality in a patriarchal context (Ljung, 1995). Rapping (1997) has described SHGs as powerful, potential revolutionary social groups that are strengthening people to talk and act in their own interests. According to Rapping, it is risky to see these kinds of groups as if they existed in a political and social vacuum, thus failing to pay attention to their political and cultural context in which gender plays an important role.

Rapping (1997) says that SHGs can, from a societal level, be seen as potential social movements. Feminist research has shown that gender is of importance for the development, characteristics, and result of all social movements, even if the participants do not explicitly assert that they actualize the struggle of gender (Taylor, 1999).

SHGs for women with chronic pain are especially relevant for study, as they combine the dealing with chronic diseases with possible gender perspective.

Aim and Method

The aim of this review is to create a survey of research on SHGs in health care with a special focus on SHGs for women with chronic muscular pain. The aim is

not only to describe this field of research, but also to examine how this research relates to issues of gender. Most of the articles selected for analysis are drawn from the field of health care.

Databases for this review include Achademic Search Elite, Sociological Abstracts, Swetswise, and Libris. The search yielded more than 100 articles responsive to the key words "self help," "self help groups," and "mutual aid" (sometimes in combination with "women/woman" and "pain").

Searches with a combination of the key words "self help group," "woman," and "pain" did not prove to be productive

In a first step the 100 articles were selected for further reading and analysis. In a second step the sources were reduced to 80 articles related to the aim of this review. In a third and final step the 47 articles that best corresponded to the focus of this article were identified. Most articles on AA and the 12-step movement were considered as irrelevant since they focused on prevention, drug treatment and relapsed drug addicts. The search was implemented at the beginning of 2004; thus no sources published later than 2003 are included in this review.

The articles were analyzed and sorted thematically by using NUD*IST (computer program for qualitative text analyses). Contents were structured by the following themes: definitions, the history of SHGs, external factors that influence SHGs, internal aspects of SHGs, and gender research about SHG.

SELF-HELP GROUPS

Definitions

Definitions of SHGs vary historically, and by group characteristics (Mäkelä, 1992). There are many similar, but not identical, definitions. The most common and central elements in the definitions focus on the mutual support and help provided by the fact that the participants come together to solve a common problem (see, e.g., Borkman, 1997, 1999; Karlsson, 2002; Katz & Bender, 1976). Another kind of mutuality notes the exchange of knowledge by the individuals in the group. The knowledge that is shared includes for example what it is like to live with the problem in everyday life and what it is like to encounter various community institutions. Researchers have called this "experiential knowledge" (see, e.g., Ben-Ari, 2002; Borkman, 1997; Karlsson, 2002). The definition also often includes something about the size of the group— that it is a small group with few participants (see, e.g., Karlsson, 2002; Katz & Bender, 1976). The organization and government of the group are factors included in some definitions, and in these cases it is said that SHGs are charac- terized by autonomy and by anti-bureaucratic organization (Adamsen, 2002; Borkman, 1997; Karlsson, 2002).

The History of SHGs

The Friendly Societies, established in England during the 18th and 19th centuries, can be seen as the very first prototypes of modern SHGs. These groups developed a system for mutual insurance and funding, and had first of all an economic function, while also assisting in other supportive activities (Karlsson, 2002; Mäkelä, 1992; Mäkelä et al., 1996).

The founding of Alcoholics Anonymous (AA) in the United States in 1935 defines a starting-point of SHGs as we know them today (Borkman, 1997; McCrady & Irvine, 1989; Vogel, Knight, Laudet, & Magura, 1998). Then came the main growth in the 1960s and 1970s together with social movements for civil rights and women's rights (Borkman, 1997). The development of SHGs distributed on the Internet in the 1990s generated a new kind of groups with members who have the benefit of not being restricted by geographical distances or by the participants' bond to home (Horne, 1999).

The common view of SHGs has changed. Roughly speaking, during the 1960s SHGs were seen as subcultures with deviant individuals that were stigmatized by society. During the 1970s the general view held that SHGs had become an anti-professional alternative. Today the SHGs are often regarded as a supplement to the official social service system (Adamsen & Rasmussen, 2001; Damen, Mortelmans & Van Hove, 2000).

The historical development of Swedish SHGs is presented by Karlsson (2002) with reference to their ideological roots. The Swedish development of SHGs has mainly been based on three traditions. These include the Swedish tradition of voluntary work, the concept of the early SHGs with roots in England and United States (AA), and the approaches of SHGs in neighboring countries developed with the help of clearinghouses. Furthermore, these traditions have been inspired by two ideological lines: the Socialist ("the ambition to co-operate") and the Christian ("the ambition to help"), considering the co-operation between the Church and the Temperance Movement (Karlsson, 2002).

The History of Women's Groups

SHGs for women can be traced back to the consciousness-raising feminist groups which were established in the 1960s and 1970s. These groups recognized and concentrated on emotional, relational, and family questions that plagued women. Within such groups women could explore their own personal pain, understand it as "non-natural," resulting from unhealthy sexual, familial, and social power. These groups involved the ambition to contribute not only to personal change, but also to societal change. The sexist outlook of society needed to be uncovered and overturned (Horne, 1999; Ljung, 1995; Rapping, 1997).

Rapping (1986) writes that women became aware that the pain and anger they felt were common as well among other women when they came together in the consciousness-raising groups of the 1960s. They learned to see that the origin of

the pain they shared originated from societal attitudes toward women, implying a possibility for change.

During the 1980s the consciousness-raising groups shifted focus from feminist questions on a societal level to personal questions, to help for members to take control of their lives (Horne, 1999). The 12-step movement developed in the same period of time to include many different addictive and compulsory behaviors such as love addiction, compulsive shopping, and difficulty to continue in life after incest or other family-based or relational difficulties. This trend resulted in the active engagement of many women in the 12-step movement (Rapping, 1997).

The development of the consciousness-raising groups for women in the 1970s took place during a decline of the struggle for women's rights. In the 1970s women's problems were seen as resulting from general gender attitudes, while today they are more likely to be viewed as personal problems.

Rapping (1997) writes that women since the 1970s increasingly have relapsed to old patterns and that their problems now are identified as "addiction." Rapping concludes that the consciousness-raising groups of the 1970s should never have asserted that the "problem" was a result of a disease called "addiction," and that the cure was to give their lives up for a higher power which, according to Rapping, sounds like a traditional patriarchal Christian God.

EXTERNAL FACTORS INFLUENCING SHGs

The conditions under which it is possible to start and run activities in SHGs are influenced both by the interplay between the SHGs and their environment, and by the context in which SHGs exist. The research findings that concern external SHG factors are structured in four parts: 1) the role of professionals within SHGs; 2) the professionals' attitudes toward SHGs, and knowledge produced; 3) the societal perspective on SHGs; and 4) the nature of social networks associated with SHGs.

The Role of Professionals Within SHGs

The role a professional social worker can play in an SHG can be fundamentally different from the role that he or she can occupy in the organization that he or she usually works in. This can be complicated because the professional may have to accept a rather less powerful role than usual (Haberman, 1990; Simpson, 1996). Research points toward some common roles that professionals can assume in SHGs. They may serve variously as consultant, as source of referral, as initiator, and as group leader (e.g., Carlsen, 2003; Stewart, 1990; Yip, 1998). One study shows that it is the role as consultant that has the greatest support by members in SHGs (Stewart, 1990).

The interaction between SHGs and professionals can be characterized as a complement to institutional service and as support, but it also challenges aspects of

the existing health care systems, (e.g., Ben-Ari, 2002; Kickbusch & Hatch, 1983; Mäkelä et al., 1996). The relation between SHGs and professionals can be described as a continuum from negative through neutral to positive relations (Horton Smith & Pillemer, 1983). Simpson (1996) asserts that it is necessary that professionals and SHGs work together to maintain a high standard in the care of the group participants and their families. Other researchers fear that the lack of information about SHGs among the professionals and the lack of preparation for useable roles within the SHGs may constitute an obstacle to service by professionals in this context (Adamsen & Rasmussen, 2001; Haberman, 1990).

THE PROFESSIONALS ATTITUDES TO SHGs
AND KNOWLEDGE PRODUCED IN SHGs

The professionals' attitudes to SHGs can be both ambivalent and varied. Researchers have found an increasing interest among professional social workers in the activities within SHGs (Adamsen, 2002; Katz & Bender, 1976). Other professional social workers have reacted negatively to SHGs by depreciating and questioning their usefulness or reliability (e.g., Baxter, 1993; Haberman, 1990; Moeller, 1983). This questioning can be interpreted as a matter of control and/or power; for example concerning the issue as to who should have the control over the information elicited within SHGs (Baxter, 1993; Karlsson, 2002; Simpson, 1996).

A negative attitude toward SHGs is reported in the health care field (Damen et al., 2000; Haberman, 1990). It is also in this field that the struggle for what kind of knowledge is to be regarded as the most important is particularly evident—the experiential knowledge of members in SHGs or professional knowledge (Karlsson, 2002; Schubert & Borkman, 1991; Simpson, 1996). Even though the professional knowledge is based on generally systematic experience and on aspects of medical science, it also may not be perfect or complete. The experiential knowledge actualized in SHGs, as what it is like to live with a chronic disease in everyday terms, is seen as directly persuasive. The assembled experience of the members of the SHGs can illustrate and embody critically significant elements of health and sickness (Ben-Ari, 2002; Simpson, 1996; Vogel et al., 1998).

Horton, Smith, and Pillemer (1983) point to factors that constitute major differences between experiential and professional knowledge: experiential knowledge represents a lively here-and-now perspective, while professional knowledge tends toward the scientific and theoretical. Yet, professional knowledge appears to have been given some kind of preferential right of interpretation which can be seen as a source of power (Högsbro, 1992; Karlsson, 2002).

Another source of power which is discussed in articles noted is the allocation of resources, with professionals often in a superior position. The professionals have the power to give or not give help, such as economic support, access to meeting places, and so on (Banks, 1997; Wituk, Shepherd, Warrren, & Meissen,

2002). The power of professionals is in opposition to the fundamental characteristics of SHGs which are defined by participation in decision-making, non-hierarchal governing, and democracy (Banks, 1997; Hasenfeld & Gidron, 1993).

A Societal Perspective on SHGs

Participation in an SHG can influence both how the participants approach the surrounding society and how they are received by it. The participation in SHGs appears to encourage the interaction between the individual and the surrounding society, and besides it has the potential to contribute to a change from being a victim to being an agent (Mehlbye & Nygaard Christoffersen, 1992; Riessman, 1965; Wituk et al., 2000). Many researchers also claim that participating in SHGs provides an increasing political and societal awareness among the members (e.g., Banks, 1997; Riessman & Banks, 1996; Vijayanthi, 2002). Also it may result in an increasing awareness among decision-makers and other people of questions raised by SHGs (Banks, 1997; Borkman, 1999; Riessman, 1997). On that basis, researchers declare that SHGs can have importance for the development of society as a whole (Damen et al., 2000, Humphreys, 1997; Högsbro, 1992).

Yet, the importance of SHGs for the development of society also has been questioned. Adamsen and Rasmussen (2001) fear that the increasing involvement of SHGs in social issues can defuse the responsibility of society, and that the responsibility for addressing social issues is transferred to an individual level. SHGs have also been criticized for causing the members to take on a role as victim or martyr (Adamsen & Rasmussen, 2001; Baxter, 1993), an opinion which is, however in turn has been rejected by other researchers (Adamsen, 2002; Riessman, 1965; Wituk et al., 2000).

Social Networks and SHGs

In an increasingly shattered society, deficient social networks are said to be the cause of people joining SHGs (Adamsen & Rasmussen, 2001; Charlton & Barrow, 2002). From that point of view it looks as if SHGs could both strengthen existing networks (Adamsen, 2002; Borkman, 1999) and empower members to create new personal networks (Adamsen, 2002; Humphreys, 1997). This two-sided effect contradicts the view that SHGs necessarily create a role as victim for SHG participants. One question implicit in this asks whether legitimacy in society can be strengthened by SHGs to increase participants' ability to claim their rights against professionals they meet and/or depend upon.

INTERNAL ASPECTS OF SHGs

What functions do SHGs fulfill for their members? Studies show that the most prominent functions are the informative and the emotional (Damen et al., 2000; Mehlbye & Nygaard Christoffersen, 1992; Wituk et al., 2000). The emotional

function is divided into two aspects: a re-socializing function and an identity-regulating function (Högsbro, 1992). The help and support that are exchanged within SHGs are not to be seen as purchasable goods but as something free, not to be bought and sold. This differs from the usual care that often involves some kind of fee (Banks, 1997; Riessman, 1997).

The research findings we have seen as internal aspects of SHGs concern different fields. Therefore we have structured the results by sub-fields: 1) reasons to participate, 2) reported personal outcomes, and 3) mutuality due to experiences, knowledge, and help.

Reasons to Participate

What makes people join SHGs and who are the people who join? Researchers appear to be limited in describing the members' origins. Nevertheless, one source reported that the major segment of participants come from the middle or upper classes, especially women in the 30-50 age range (Mehlbye & Nygaard Christoffersen, 1992). In his review, Karlsson (2002) describes the typical participant in SHGs as a white, well-educated, young, and unmarried woman. People from middle class are overrepresented and ethnic minority groups are underrepresented (Borkman, 1997).

The reason for participation appears to be various. Hatch and Kickbusch (1983) claim that one reason for people with chronic diseases to participate is to adapt to an everyday life with the actual disease, not to recover. Other reasons to participate relate to lack of support in existing social networks, and the need to "normalize" the sickness (Charlton & Barrow, 2002). Another reason presented by Charlton and Barrow suggests that people join an SHG because they need a special kind of support that only people with the same kinds of experience can provide. Further reasons to join an SHG include the desire to meet others in a similar situation, to help oneself and others, to join the group's social activities (Richardson, 1983), and, from a societal level, to change the situation for others with the help of SHGs (Moeller, 1983; Richardson, 1983).

Reported Personal Outcomes

Researchers have pointed to mostly positive outcomes derived from participation in SHGs. This can in some cases be explained as an effect of the fact that SHGs seldom have members that do not see SHGs as helpful to them. Such persons usually leave the activities after a few initial visits, and therefore are not included in subject studies (Mehlbye & Nygaard Christoffersen, 1992).

The participants staying in the SHGs reported many positive outcomes along different dimensions. Several studies show outcomes relating to higher self-esteem, self-confidence, and self-understanding (see, e.g., Chamberlin & Rogers, 1996; Riessman, 1965, 1997). Another outcome reported notes a

decreased feeling of isolation and stigmatizing (e.g., Borkman, 1999; Krause, 2003; Vogel et al., 1998).

The participation in SHGs provides both emotional and social support (e.g., Borkman, 1999; Krause, 2003; Wituk et al., 2000). Furthermore, participation can result in new attitudes to and new perspectives on participants' selves and their problems, and clarification of views of other people (Adamsen, 2002; Mok, 2001; Wituk et al., 2000). Researchers have also claimed that participation in SHGs can strengthen relationships and family ties, and may help in the creation of new social networks (Adamsen, 2002; Borkman, 1999; Humphreys, 1997).

Mutuality Due to Experiences, Knowledge, and Help

SHGs include mutual exchange according to experiences, knowledge, and support. The fact that the participants both give and receive support appears to have plural functions where the giving of help is of importance. Some researchers name the effect of giving help "The Helper Therapy Principle," and the helping appears to be of great importance for the personal changes reported by participants.

The consequences of helping others are said to contribute to increased self-esteem, self-confidence, and a feeling of importance in relation to others (e.g., Borkmam, 1999; Medvene, Wituk & Luke, 1999; Riessman, 1965, 1997). The mutual exchange of knowledge that takes place within the SHGs is based upon the participants' different and common experiences, and according to researchers it differs from conventional professional and scientific knowledge (e.g., Borkman, 1997, 1999; Hasenfeld & Gidron, 1993; Karlsson, 2002).

GENDER RESEARCH ABOUT SHG

Only a few sources were found focused specifically on groups of women, although groups of women frequently exist in SHGs—for example SHGs for women with breast cancer. Given this relative lack of data, these articles cannot be seen as a substantial foundation for gender analysis. However, the following section discusses the presence and impact of gender in relation to three topics identified by the research cited: 1) groups of women, 2) the individualization and the medicalization of women's problems, and finally 3) internal and external outcomes in female SHGs.

Groups of Women

Today, groups of women and women's networks differ in contents, aim, form of organization, and political affiliation. Ljung (1995) writes that women can be in need of their own contexts, not to draw back, but to act on their own terms. But Ljung suggests that the group can also function to create social environments where women can fulfill mutual needs for confirmation, support, and

acknowledgment needed in confrontation with male structures in their working lives. Glaser (1976) also has studied women's SHGs and observes that women who like to meet with other women, get together to do something about their own problems and help each other. They like being responsible for their own well-being and feel that they can make changes in their lives.

The Individualization and the Medicalization of Women's Problems

The professionals in health care systems have seen it as important to provide financial support to meet women's emotional problems. Rapping (1986) understands this as a way for professionals to individualize and to see women's problems and emotional pain as sickness. Women's reactions to emotional problems are often individualized, but women's emotional problems can also be seen as a reaction to the social construction of womanhood, according to Rapping. She refers to Foucault as she claims that public confessions (which are common in the 12-step movement) always have been a subtle form of social control. You think you are exposing your inner-most thoughts and talk from deep in your soul after having been silenced in a long period of formality. Instead, by public confession, you commit yourself even more deeply to the restraining norms of public discourse (Foucault, 1990; Rapping, 1997). The approval of such public confession can imply that the change you wish to obtain by participating in an SHG can, conversely, result in a reproduction of the existing norms, including the established meaning of gender in society.

Internal and External Outcomes of Female SHGs

In a comparative study of female groups and groups of mixed gender (Horne, 1999), differences were found between the groups in terms of outcomes for the group members. In the groups with women only, the participants were more depending on each other, while the members in the mixed groups increased their contacts outside the group. In Horne's interpretation, women in a group become more intimate with each other. The female groups focused more on questions of what it is like to be a woman, and the activities contained fewer aspects of power than found in mixed groups.

The female groups also involved an atmosphere that allowed expression of stronger feelings, and emotional support was more highly valued than the solving of problems (Horne, 1999; Rapping, 1986). The development of strong intimate relations within a female group can also be seen as something negative for some members. In one study Ljung (1995) showed that there was an uncertainty among the members in an SHG whether they would be accepted if they developed in another direction than their "sisters." Moreover, according to this study, some of the members said that it was difficult for them to express differences and to break up from the group (Ljung, 1995).

A study of a community development project in India that aimed to empower women by participation in SHGs showed that the women increased their knowledge and power to decide, both individually and in groups. The women also became more powerful m decision-making, according to themselves and their children, and increased their ability to take active part in local boards and to achieve better economic self-sufficiency (Vijayanthi, 2002).

To sum up—the development of female SHGs has gone on for more than 30 years. Horne (1999) claims that research has not been especially focused on female groups during the last 20 years. Therefore she sees it as necessary to further evaluate research m this field. We also see it as necessary to consider how gender and power relations are important in the activities of SHGs.

CONCLUSION

There are many similar but not identical definitions of SHGs. The most common characteristics of SHGs are mutuality in reference to giving and getting help, support, and knowledge; the small size of the groups, and their autonomous organization. In some cases, the SHGs are "ruled" by professionals, which can contradict the characteristic of SHGs as autonomous groups.

The history of SHGs can be traced to the 18th century in England, but the starting point of contemporary SHGs is the foundation of AA in the United States 1935. However, the main growth of SHGs came about during the 1960s and 1970s together with social movements for civil rights and women's rights, and this was also the time when female groups, most of them consciousness-raising, started to develop.

Over time, female groups have changed from groups that made women aware of the construction of womanhood and therefore made them challenge society's attitudes toward women, to SHGs which are strongly influenced by the 12-step movement where the problems are individualized. For that reason we find it of interest to study SHGs for women, to examine how gender norms are constructed by the members of SHGs and if so whether they challenge society's attitudes toward women. Is it possible for women with, in our case, chronic muscular pain to become aware of the construction of gender and womanhood with the help of SHGs and to take on new meanings of gender construction and womanhood? Or do they reproduce in SHGs the existing societal norms of gender?

The external factors that appear to influence SHGs are the roles of professionals and their attitudes toward SHGs, the power exercised by professionals, and the societal context. Researchers have shown that members of SHGs use public resources to a higher degree than others (Borkman, 1999; Charlton & Barrow, 2002). We do not know if SHGs strengthen members to use public resources, or if they facilitate information or knowledge about what resources to use. It is difficult for women with chronic muscular pain with no pathological findings to get acknowledgment of and legitimacy for their sickness, and they often experience

that they are distrusted by health care service providers (Malterud, 1994; Säljö & Sätterlund-Larsson, 1996). Research has shown that SHGs can reduce feelings of stigma (e.g., Borkman, 1999; Krause, 2003; Vogel et al., 1998). Whether this also relates to improved perceived legitimacy is still to be investigated, and we see women with chronic muscular pain as a well-suited target group for such an investigation.

Previous research has also shown that it looks as if there is an opposition and a struggle for power between professionals on one hand, and participants in SHGs on the other, about what is communicated in the groups by way of knowledge and information. Researchers have presented this in terms of differentiating the kinds of knowledge, such as the experiential knowledge of the participants, in contrast to the professionals' scientific knowledge. In gender studies the sources of data are often the individual's own experiences and the knowledge generated by these experiences (Harding, 1998; Widerberg, 1995).

Feminist research speaks about "situated knowledge": you talk from the position and body you are in, and "local claims of knowledge": you talk about something you know and can stand for (Harding, 1998; Widerberg, 1995). This feminist view of knowledge can be compared with what research about SHG describes as experiential knowledge (Horton Smith & Pillemer, 1983). The dichotomizing of scientific and experiential knowledge, where differences rather than similarities are highlighted, should be analyzed and reviewed from a gendered perspective. Asserted differences between these conceptualization of knowledge are not necessarily definitive (Fahlgren, 1999).

When it comes to the internal aspects of SHGs, researchers have shown that reasons for participation stated importantly include mutuality—mainly concerning help, support, and the exchange of knowledge. SHG members have also reported that they experience the activities in the group and the outcome of their participation as personally positive.

At the same time, researchers have reported that chronically ill participants more often have need to adapt to everyday life with the disease, rather than emphasizing recovery. What does such adaptation mean, and what or who decides what to adapt to? Can what to adapt to differ depending on the characteristics of the initiator of the group? It is possible to determine if there are differences if the group is initiated by professionals or by peers?

Moreover, what is told within the SHG, the information and the knowledge distributed, can be strongly influenced by societal norms. We do not know if the positive outcome that is reported is built only upon the confirmation of and adaptation to norms and expectations (for example, the sick-role and the gendered expectations that the participants bring with them into the group activities), or if new ways to manage the situations are produced. Questions remain whether SHGs reproduce the roles that the participants already have established or whether social change and new attitudes are created? And what is the impact of gender in this reproduction/social change process? A gender perspective opens up the

possibility of examining the problems in context of the construction of woman-hood and as elements in the incorporation of societal norms.

FURTHER RESEARCH

SHGs do not exist isolated from the surrounding society with its norms and expectations. We see the contextual factors and the societal influence as important. SHGs are also influenced by internal factors. When the SHG participants talk about their problems, their experiences, and so on, there is mutual exchange among them. The consequences of this exchange and the importance and influence of the context in this exchange remain to be studied, especially with a gender perspective. We believe that gender norms are of great importance in this con-nection, but we do not know how societal norms including the importance of gender are produced and conserved in the SHGs, and whether and how new meanings of norms and gender are produced.

We have identified a relative lack of a gender perspective in SHG research. In the particular field of SHGs for women with muscular pain, more research with focus on what the women experience in their participation is needed. In general, SHG research needs to examine if the members, with the help of the interaction/exchange in the SHGs, can produce new ways to manage their lives with reference to gender construction, knowledge, legitimacy, and adaptation/transformation, or if the activities in the SHGs reproduce existing norms and attitudes in society.

CLOSING WORDS

Existing research lacks attention to investigating the ways in which SHGs are important to implement or revise societal gender constructions. Likewise, there is a lack of knowledge about the question whether the participant's relations to the surrounding society are preserved or changed in terms of adaptation and legitimacy. It is possible to assume that women with chronic muscular pain are influenced not only by their low legitimacy within the health care sector, but also by their subordination as women and, moreover, by the norms and perceptions that are mediated and reproduced just because they are women with pain? More research on this group presents a new strategy, both in relation to our knowledge about SHGs and in gender science.

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